

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00544

166

Reg. Dist. No.

1. PLACE OF DEATH:

County: Garrett, Maryland.

City or town: Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

William Rudolph Beckman.

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: widower

6. (b) Name of husband or wife:

7. Birth date of deceased (mo., day, yr.): December 3d, 1865

8. AGE: Years: 79 | Months: 1 | Days: 6 | If less than one day: hrs: min:

9. Birthplace: Kitzmiller, Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

12. Name: Rudolph Beckman.

13. Birthplace: Germany

14. Maiden name: Elizabeth O'Brien.

15. Birthplace: Garrett County.

16. Informant: Russel Beckman.

Address: Oakland, Maryland.

17. Burial: Date thereof: January 11/45
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory: Oakland Cemetery.
Location: Oakland, Maryland.

18. Funeral director: Emroy D. Bolden.

Address: Oakland, Maryland
Jan - 10 - 45
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland | County: Garrett

City or town: Oakland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9th 1945 5:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from PM.
1 - 24 - 44 1945 to 1945 19

and that I last saw h. . . . alive on 1945 19

Immediate cause of death: Chronic Bronchitis

Due to: Chronic Nephritis

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

Where did injury occur? (City or town) (County) (State)

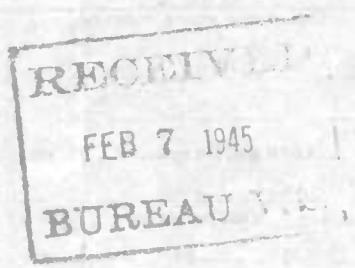
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: *Rudolph Beckman*

M. D. or other

Address: Oakland, Maryland Date signed: 1-10-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore B-2

CERTIFICATE OF DEATH

00545

161

Reg. Dist. No.

1. PLACE OF DEATH:

County... Garrett

City or town... Rural-FRIENDSVILLE, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Home

How long in hospital or institution?

3. (a) FULL NAME

Anna Belle Fike

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife.

Harrison Bell Fike

Aug. 31, 1860

6. (c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state) Maryland

10. Usual occupation

Housewife

11. Industry or business

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Cemetery or crematory

Date thereof

(month) (day) (year)

Location

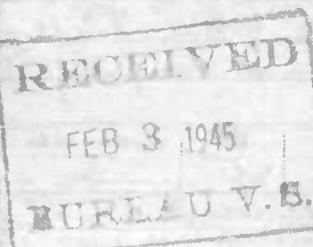
18. Funeral director

Address

19. (Date rec'd by registrar)

19. (Date of death)

19. (



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-d

00546

166

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH: Garrett
County: Garrett
City or town: Mt. Lake Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death: 2 years
Hospital, institution, or street address where death occurred: Kisers Nursing Home
How long in hospital or institution: 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Grant
City or town: Bayard
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (b) Social Security Number: -----

3. (a) FULL NAME
John Henry Forsyth

4. Sex: Male Color or race: White Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Sarah Virginia Winters
Forsyth

7. Birth date of deceased (mo., day, yr.): June 13, 1864
.....(c) If alive, give age: ----- years

8. AGE: Years: 80 Months: 7 Days: 6 If less than one day: hrs: min:

9. Birthplace: Preston Co., W. Va.
(Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business: Bituminous Coal Mines

FATHER: 12. Name: Alexander Forsyth
13. Birthplace: Scotland

MOTHER: 14. Maiden name: Unknown
15. Birthplace: -----

16. Informant: James R. Forsyth
Address: 319 So. Newcreek St.; Balto., Md.

17. Burial: Jan. 20, 1945
(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)
Cemetery or crematory: Bayard Cemetery

Location: Bayard, W. Va.

18. Funeral director: Herbert C. Keighton
Address: Oakland, Md.

19. (Date rec'd by registrar): Jan. 19, 1945
Registrar: Julia A. Rowan

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18, 1945 19.....12:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1-14-45 19.....12:10 P.M. to 1-15-45 19.....12:10 P.M.
and that I last saw her alive on 1-15-45 19.....12:10 P.M.

Immediate cause of death: General Debility Heart Attack

DURATION: -----

Due to: -----

Valvular Heart Lesion

Due to: -----

Other conditions: -----

(Include pregnancy within 8 months of death)

Major findings of operations: -----

Date of op: -----

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of: -----

Where did injury occur? (City or town) (County) (State)

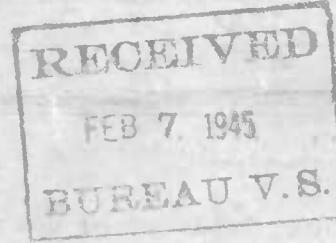
Injured at home, farm, industry, public place (where?)

Means of injury: -----

Injured at work? -----

23. SIGNATURE: *Herbert C. Keighton*
Address: Oakland, Md. M. D. or other

Date signed: 1-19-45



M

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

00547

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

Garrett

County

Oakland, Maryland.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Life time

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

Mary Eleanor Frantz.

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widow

6 (b) Name of husband or wife Edward J. Frantz.

Deceased

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 24th, 1864

8. AGE: Years Months Days If less than one day

80 2 .21 hrs. min.

9. Birthplace Garrett County.

(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name James A. Dunham.

13. Birthplace Pennsylvania.

14. Maiden name Elizabeth Morris.

15. Birthplace Pennsylvania.

16. Informant Miss Cora Frantz.

Address Oakland, Maryland.

17. Burial Date thereof January 17/45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oakland Cemetery.

Location Oakland, Maryland.

18. Funeral director Emroy D. Bolden.

Address Oakland, Md.

19. Date rec'd by registrar

1945

Julia A. Rowan

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County County

Oakland, Maryland.

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15 1945, at 10:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from A.M.

August 19 44, to Jan. 19 45,

and that I last saw her alive on Jan. 14 1945.

Immediate cause of death

Generalized arteriosclerosis

DURATION

10 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

At autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

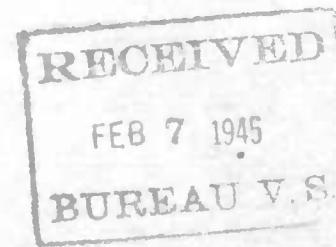
23. SIGNATURE

Edgar Banister

M. D. or other

Address Oakland, Md.

Date signed 1/16/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1312

00548

CERTIFICATE OF DEATH

Reg. Dist. No. 161

1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Mary Louise Friend

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

Never married

7. Birth date of deceased (mo., day, yr.)

Feb 28-1885

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

59

10

27

9. Birthplace

(Town, county, and state)

Friendsville, Md

10. Usual occupation

Helps around house

11. Industry or business

Andrew Friend

12. Name

Andrew Friend

13. Birthplace

Friendsville, Md

14. Maiden name

Mary Lish

15. Birthplace

Friendsville, Md

16. Informant

Mary Friend

Address

Friendsville, Md

17. Cemetery or crematory

T.B. Cemetery, Rose

(Burial, cremation, or removal? Which?)

Date thereof Jan 28-45
(month) (day) (year)

Location

Mary Friend's home

18. Funeral director

St. John's Garage

Address

Friendsville, Md

19. Date rec'd by registrar

Jan 27, 1945 Ida Rush

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Mar Friendsville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

Jan. 25

45

2 A.M.

20. DATE OF DEATH Jan. 25 1945 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 7 1942 to Jan. 25 1945

and that I last saw her alive on June 10 1944

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to Arteriosclerosis

?

Due to

Other conditions Nephritis

?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

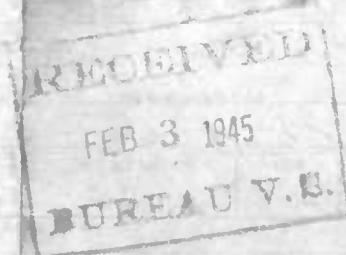
Means of injury Injured at work

23. SIGNATURE

H. J. Glavin M.D.

M. D. or other

Address Friendsville, Md Date signed Jan 26 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00549

161

Reg. Dist. No.

1. PLACE OF DEATH

County

Baltimore

City or town

Baltimore

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

3. (a) FULL NAME

Webster Friend

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M.

W.

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

July 14, 1871

8. AGE:

73

6

19

Days

If less than one day

hrs. min.

9. Birthplace

(Town, county, and state)

Md. Baltimore

10. Usual occupation

Book Dealer

11. Industry or business

12. Name

H. J. Friend

13. Birthplace

Md.

14. Maiden name

Phoebe Ellen Lauchrey

15. Birthplace

Accidents Md.

16. Informant

H. J. Friend

Address

Baltimore

17. Burial

(Burial, cremation, or removal, where?)

Date thereof Jan. 6 - 45

(month) (day) (year)

Cemetery or crematory

Friendsville Md.

Location

Friendsville Md.

18. Funeral director

H. J. Turner

Address

Friendsville Md.

19. Date rec'd by registrar

Jan. 6, 1945

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)

State

Md.

County

Baltimore

City or town

Friendsville Md.

Street No.

(If outside city or town limits, write RURAL and give nearest town)

2.(a) If veteran, name war

3. (b) Social Security Number

0

MEDICAL CERTIFICATION

20. DATE OF DEATH

Jan. 3

1945

at 12 noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 8

1941

to Jan. 3 1945

and that I last saw h. im alive on Nov. 12

1944

Immediate cause of death

Carcinoma of descending colon

DURATION

Due to ?

10 year

Due to

Other conditions Senility.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

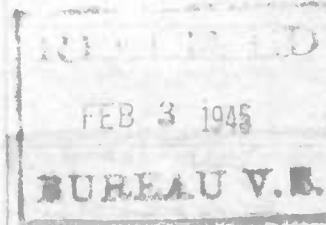
23. SIGNATURE

H. J. Glover, M.D.

M. D. or other

Address Friendsville, Md.

Date signed Jan. 5-45



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

00550

Reg. Dist. No. 171

1. PLACE OF DEATH: Garrett
County: R.D. Accident
City or town: (If outside city or town limits, write RURAL and give nearest town) Life
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Garrett
City or town: R.D. Accident
(If outside city or town limits, write RURAL and give nearest town)
Street No.: (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME

Flavius Josephus Glotfelty

4. Sex: M	5. Color or race: W	6.(a) Single, married, widowed, or divorced: Widowed
-----------	---------------------	--

6.(b) Name of husband or wife: Elizabeth Glotfelty

7. Birth date of deceased (mo., day, yr.): October 15 1860

8. AGE: Years: 84	Months: 2	Days: 18	If less than one day: hrs. min.
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9. Birthplace: R.D. I. Accident
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER: 12. Name: Nimrod Glotfelty
13. Birthplace: Salisbury Pa

MOTHER: 14. Maiden name: Magdalena Broadwater
15. Birthplace: R.D.2 Grantsville Md

16. Informant: Mrs Myrtle Broadwater
Address: Grantsville Md

17. Burial: Date thereof: 1-6-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Glotfelty
Location: R.D. I. Accident Md

18. Funeral director: Mrs. Winterberg
Address: Grantsville Md

19. Date rec'd by registrar: Jan. 5 1945
Signature: J. B. Emery
Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2 1945 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19. to 19. and that I last saw h. alive on 19.

Immediate cause of death:

Paralysis of vocal Cords

Due to: arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of:

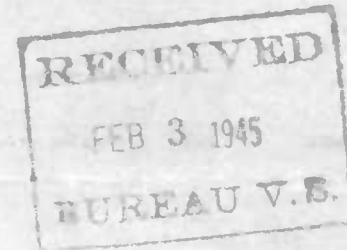
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: B. J. Baumgartner M.D.

M. D. or other
Address: Dalland, Md Date signed:



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00551

830

CERTIFICATE OF DEATH

Reg. Dist. No. 171

1. PLACE OF DEATH:

County..... Garrett
 City or town..... Rural Near Jennings
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... Life
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Louis Hoover

4. Sex M W Married
 5. Color or race Single, married, widowed, or divorced

6. (b) Name of husband or wife..... Stella M. Hoover

7. Birth date of deceased (mo., day, yr.)..... July 15-1886
 6. (c) If alive, give age..... 55 years

8. AGE: Years 58 Months 6 Days -- If less than one day
 hrs. min.

9. Birthplace..... Rural Near Jennings Garet Co-Md
 (Town, county, and state)

10. Usual occupation..... Coal Miner

11. Industry or business

MOTHER FATHER Name..... Chancy Hoover
 Birthplace..... Near Jennings Md

MOTHER Name..... Elmaria Bittinger
 Birthplace..... Near Jennings Md

MOTHER Name..... Mrs Stella M. Hoover
 Birthplace.....

16. Informant.....
 Address..... Jennings Md

17. Burial..... Date thereof..... 1-17-1945
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Charles Hoover
 Location..... Near Jennings Md

18. Funeral director..... Wm. Winterberg
 Address..... Grantsville Md

19. Date rec'd by registrar..... Jan. 16 1945
 (Date rec'd by registrar) J.B. Enny
 Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md County..... Garrett

City or town..... Rural Near Jennings
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

213-18-2632

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Jan 15 1945 at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13 1945 to Jan 15 1945
 and that I last saw him alive on Jan 15 1945

Immediate cause of death..... *bleeding
hemorrhage*
 DURATION *3 days*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

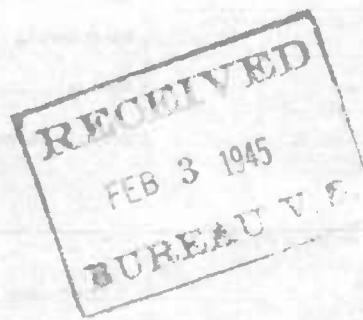
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... *H. R. Davis M.D.*
 M. D. or other

Address..... Grantsville Date signed..... Jan 17



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

00552/66

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County Garrett
City or town Hutton

(If outside city or town limits, write RURAL and give nearest town)

16 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Benjamin Hamilton Long

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife

Eva Johnson Long

June 6, 1863

6. (c) If alive, give age years

68

7. Birth date of deceased (mo., day, yr.)

June 6, 1863.

8. AGE:

Years

Months

Days

It less than one day

81 7 22

. hrs. . min.

9. Birthplace Mt. Olivet, Pa.

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

General

12. Name Gidion Long

13. Birthplace Fredrick, Md.

14. Maiden name Mary Keener

15. Birthplace Fredrick, Md.

16. Informant Mrs. Eva Johnson Long

Address

Hutton, Md.

17. Removal and Burial (Date thereof) Jan. 30, 1945
(Burial, cremation, or removal. Which?) (mouth) (day) (year)

Cemetery or crematory Monongahela

Location Maple town, Pa.

18. Funeral director Collation

Address

Terra Alta, W. Va.

19. (Date rec'd by registrar)

19

45 Julia Rowan

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Hutton (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

No

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

January 28th 1945 at 3:40 A.M.

2D. DATE OF DEATH

2d. I CERTIFY that death occurred on the date above stated; that I attended deceased on December 24, 1944, to 1944

and that I last saw h. surviving on December 24, 1944

Immediate cause of death Not Known

DURATION

Due to Cancerous of Stomach 2 yrs.

Due to Cancerous of Stomach 2 yrs.

Other conditions Retention of urine due to obstructive lesion

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

*Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

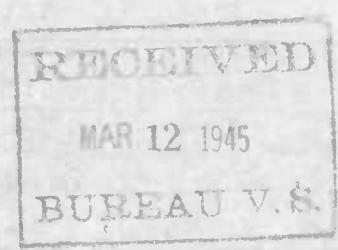
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Egton, W. Va. Date signed 1/29/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

CERTIFICATE OF DEATH

Benn53 2166
Reg. Dist. No.

1. PLACE OF DEATH:

Garrett
County.....

Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Martha McComas McIntire.

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Married.

6. (b) Name of husband or wife..... Paul W. McIntire

7. Birth date of deceased (mo., day, yr.)..... April 16th, 1903

(6. c) If alive, give age..... years

8. AGE: Years Months Days If less than one day
41 9 3 hrs. min.

9. Birthplace..... Oakland, Maryland.

(Town, contry, and state)

10. Usual occupation..... House wife

11. Industry or business

FATHER 12. Name..... Henry Wheeler McComas.

13. Birthplace..... Oakland, Maryland.

MOTHER 14. Maiden name..... Annie West.

15. Birthplace..... Swanton.

16. Informant..... Mrs. Nelle Lawrence.

Address..... Oakland, Maryland.

17. Burial Date thereof..... Jan. 22/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Oakland Cemetery.

Location..... Oakland, Maryland.

18. Funeral director..... Emroy D. Bolden.

Address..... Oakland, Maryland.

Jan 21-45
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Garrett

City or town..... Oakland, Maryland.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... January 19 th 1945, at 11:00 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from P. M

Aug 1 1943, to Jan 19 1945

and that I last saw her alive on Jan 19 1945

Immediate cause of death.....

Carcinoma of breast

With metastasis to

Due to: lump lower, neck

Due to:.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Carcinoma

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

L. J. Baumgartner M.D.

M. D. or other

Address..... Oakland, Maryland Date signed Jan 20 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00554

CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH: Garrett
 County: Jennings
 City or town: (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 Years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State: Md County: Garrett
 City or town: Jennings (If outside city or town limits, write RURAL and give nearest town)
 Street No.: (If rural, give LOCATION)
 2.(a) If veteran, name war:

3. (a) FULL NAME

Henry Platter

4. Sex: M 5. Color or race: W 6.(a) Single, married, widowed, or divorced
 W Married

6.(b) Name of husband or wife: Anna Handwerk

7. Birth date of deceased (mo., day, yr.) March 21-1872
 B.(c) If alive, give age: 71 years

8. AGE: Years: 72 Months: 9 Days: 25 If less than one day
 hrs: min.

9. Birthplace: Rural Near Bittinger Garrett, Md
 (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

12. Name: Henry Platter

13. Birthplace: Germany

14. Maiden name: Rachael Bittinger

Bittinger Md

15. Birthplace:

16. Informant: Henry Platter

Address: Grantsville Md

17. Burial: Date thereof: 1-19-1945

(Burial, cremation, or removal. Which?) Date thereof: (month) (day) (year)

Cemetery or crematory: Bittinger

Location: Bittinger Md

18. Funeral director: John Wintersburg

Address: Grantsville Md

19. Date rec'd by registrar: Jan 18, 1945

Ethel Broadwater

Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

2D. DATE OF DEATH: Jan 16 1945 at 12:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1945 to Jan 16 1945

and that I last saw him alive on Jan 14 1945

Immediate cause of death:

Carcinoma of Rectum

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury:

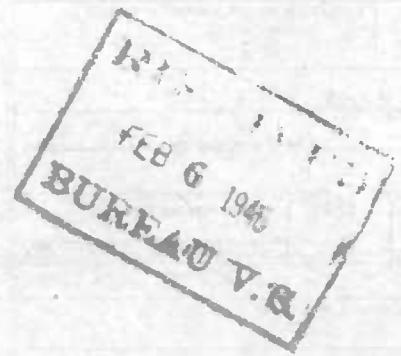
Injured at work?

23. SIGNATURE: J. B. Davis M.D.

M. D. or other

Address: Grantsville Date signed: Jan 17

REASON TO IDENTIFY STATE-OF-ORIGIN
REASON TO IDENTIFY



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00555

CERTIFICATE OF DEATH

Reg. Dist. No. 162

M

MARGIN RESERVED FOR BINDING

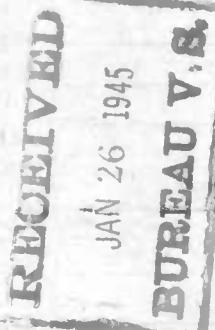
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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County Garrett		
City or town R. D. Grantsville (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?		
Hospital, Institution, or street address where death occurred:		
How long in hospital or institution?		
3. (a) FULL NAME Clyde Edgar Scell		
4. Sex M	5. Color or race W	6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Margaret Scell		
7. Birth date of deceased (mo., day, yr.) February 7 - 1912 B. (c) If alive, give age 25 years		
8. AGE: Years 32		
Months II		
Days 6		
If less than one day hrs. min.		
9. Birthplace Elk Lick T. S. Somerset Co. Pa (Town, county, and state)		
10. Usual occupation Truck Driver		
11. Industry or business		
12. Name Howard F. Scell		
13. Birthplace XXXXXXXX Missouri		
14. Maiden name Anna Klink		
15. Birthplace Elk Lick T. S. Somerset Co. Pa		
16. Informant Mrs Margaret Scell		
Address Wellersburg Pa		
17. Burial Date thereof I-16-1945 (Burial, cremation, or removal. Which?) Cemetery or crematory Fink		
Location On Glenco Pa Road		
18. Funeral director Mrs. Winklesburg Address Grantsville Md		
19. Date rec'd by registrar Jan 14 45 Ether Swadlinton Registrar		

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)		
State Pa	County Somerset	
City or town Rural Wellersburg (If outside city or town limits, write RURAL and give nearest town)		
Street No. (If rural, give LOCATION)		
2. (a) If veteran, name war		
3. (b) Social Security Number 215-10-1293		

MEDICAL CERTIFICATION		
20. DATE OF DEATH Jan 13 1945 at 11:00 A.M.		
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19. to 19. and that I last saw h. alive on 19.		
Immediate cause of death Carbon Monoxide poisoning		
Due to Man went to sleep in cab of truck with motor running		
Other conditions (Include pregnancy within 3 months of death)		
Major findings or operations Date of op.		
Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.		
22. VIOLENCE: If death was due to external causes fill in the following: Accident, suicide, or homicide Date of Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) On Highway 40 Means of injury Injured at work? Address H. P. Davis M.D. M. D. or other Date signed Jan 13 1945		
23. SIGNATURE Address Grantsville Md		



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00556

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Garrett

County

Mt. Lake Park,

(If outside city or town limits, write RURAL and give nearest town)

6 years

How long in above place of death?

Hospital, institution, or street address where death occurred:

Kiser's Nursing Home

6 years

How long in hospital or institution?

3. (a) FULL NAME

Eliza Schooley

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) April 25, 1855

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

89 8 13

hrs. min.

9. Birthplace

Garrett Co., Md.

(Town, county, and state)

10. Usual occupation

in Homes

11. Industry or business

William Schooley

12. Name

Unknown

13. Birthplace

Clarissa Schrock

14. Maiden name

Unknown

15. Birthplace

Thomas O. Schooley

16. Informant

Mt. Lake Park, Md.

Address

Burial

17. (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Deer Park Cemetery

Location

Deer Park, Maryland.

18. Funeral director

Herbert C. Leighton

Address

Oakland, Maryland.

19. (Date rec'd by registrar)

Jan-9-45

19

Julia Roseau

Local

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

Maryland

County

Garrett

City or town

Mt. Lake Park

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

January 7, 1945

19

9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-2-44

19

to 1-7-45

19

and that I last saw her alive on 1-5-45 19

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 hour

Due to

Arterio sclerosis and Chronic Nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

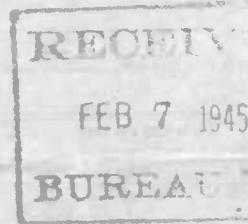
Injured at work?

23. SIGNATURE

Edward N. Johnson

M. D. or other

Address Date signed 1-8-45



RECEIVED
FEB 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

00558.

CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH:

County GarrettCity or town Deer Park

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty GarrettCity or town Deer Park

Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR World War I

3. (a) FULL NAME

Edward Ray Thrasher

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) October 28, 18968. AGE: Years 48 Months 2 Days 8 It less than one day hrs. 00 min. 009. Birthplace Deer Park, Maryland
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

12. Name William H. Thrasher13. Birthplace Winchester, Va.14. Maiden name Elizabeth Jankey15. Birthplace Piedmont, W. Va.16. Informant Mrs. Albert ThrasherAddress Oakland, Md.17. Burial Date thereof Jan. 7 1945
(Burial, cremation, or removal. Which?) Deer Park

(month) (day) (year)

Cemetery or crematory Deer ParkLocation Deer Park, Md.18. Funeral director Emroy D. BoldenAddress Oakland, Md.19. Jan. 6, 1945
(Date rec'd by registrar)Registrar Julia Rowan

MEDICAL CERTIFICATION

20. DATE OF DEATH January 5 1945 5 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Examined after death 19 to 19,and that I last saw h alive on 19 19

Immediate cause of death

Fourth degree burns entire bodyDue to Destruction of house by fire.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Dt operations

Dt autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/5/45Where did injury occur? Deer Park, Garrett, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) HomeMeans of injury Burns Injured at work? No23. SIGNATURE Julia RowanM. D. or other Reg. No. 166Address Deer Park, Md. Date signed 1/6/45

